Basic Medicaid Workshops
October 2007 Seminar Registration Form
(No Fee)

Provider Name_____
Medicaid Provider Number_____NPI Number_____
Mailing Address_____
City, Zip Code_____County_____
Contact Person_____E-mail_____
Telephone Number(____)_____Fax Number_____

1 or **2** person(s) will attend the seminar at _____on_____
(circle one) (location) (date)

Please fax completed form to: 919-851-4014
Please mail completed form to:
EDS Provider Services
P.O. Box 300009
Raleigh, NC 27622